

Here's
your first
issue of *Seasons*

For the best times of a woman's life.

Seasons™

Volume 1, Issue 1



Menopause
At last, the real facts

Home Stretch—
Revive tired muscles

Plus...
Health tips you can use

Published by Wyeth-Ayerst Laboratories

Welcome to *Seasons*TM Magazine!

Brought to you by Wyeth-Ayerst Laboratories, makers of
PREMARIN® (conjugated estrogens tablets)

If you're like me, and the millions of other women who begin menopause each year, you probably have more questions than answers.

Questions like:

- Should I stop taking estrogen when the hot flashes stop?
- If I take calcium every day, will I prevent osteoporosis?
- Is sex less satisfying after menopause?
- Are these symptoms all in my head?

If you thought the answers to all of the above questions were "yes," you're just like most women who *haven't got all the facts* about menopause.

The fact is that practical information about menopause *is* available. What's more, there are positive steps you can take to feel and look your best now...and in the good years to come.

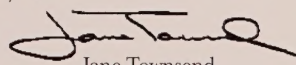
While menopause is the end of one phase in your life, it also marks the beginning of a very exciting and productive *new* era. Our generation may be the first to truly make the mature years our best years. Our outlook on life is different from that of our mothers and grandmothers. We are vital...and just beginning to understand how much the future holds for us and our families.

Seasons Magazine promises to help make this change in life as smooth and enlightening as possible — by providing the information needed to make some very important decisions. By better understanding the changes in your body during this stage of life, you can take a more active role in your PREMARIN treatment program. I'm proud to be an editor of this magazine, and will do everything I can to bring you valuable, practical and thought-provoking articles.

Seasons Magazine is planned to be much more than paper in the mail. Hopefully, it will become a reliable resource...like a friend who helps, and a friend who listens. It will keep you up to date on medical, health and beauty topics. Each issue will include a column that helps you get the information you need from your physician. Plus, another column to help you discuss menopause-related issues with your partner and other family members. *Seasons* will help you look your very best by featuring beauty and exercise tips aimed at women 45 and older. And articles will delve into issues such as sexuality and relationships — all geared to the concerns of women at your stage in life.

Last but not least, *you* will play an important role in the magazine (if you wish). As editor, I'll invite your opinions about articles, want to know more about your personal experiences and ask you to answer survey questions. By opening up this two-way communication, our readers can all learn from each other's experiences, and begin to break down the information barriers which so often surround "women's issues."

I'm so glad you subscribed to *Seasons* Magazine, and look forward to hearing from you.


Jane Townsend
Executive Editor

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From the office of...

Dr. Marc W. Deitch

Vice President, Medical Affairs and Medical Director
Wyeth-Ayerst Laboratories

Dear Patient,

Years ago, many women and caregivers dismissed the symptoms of menopause. As a result, it was rarely, if ever, discussed. Today, we know that there are physical — hormonal — reasons for symptoms such as “hot flashes” and “night sweats.”

This issue of *Seasons*[™] Magazine, provided to you by Wyeth-Ayerst, includes an article that separates the myths from the facts about menopause.

I hope you will find it interesting and informative. I also hope that the articles you read will become a starting point for discussions. Feel free to discuss your symptoms, no matter how trivial they may seem. The very fact that this magazine exists should give you reason to believe that *you are not alone*. Millions of other women have concerns that are similar to yours. Take your next office visit as an opportunity to discuss any of the issues the articles raise.

Good reading...and good health!

A word about the medication
your physician has prescribed for you

PREMARIN[®]

(conjugated estrogens tablets)

PREMARIN is the most widely prescribed estrogen replacement therapy. Physicians have prescribed PREMARIN for millions of patients. PREMARIN has been widely studied and investigated, and research continues to find new uses for it. For example, PREMARIN is currently the only estrogen therapy proven to prevent osteoporosis (bone loss) and reduce the risk of related fractures. Osteoporosis occurs in one of every four women after menopause. For more information, consult your physician.

We thought you would like to know more about the medication you are taking. We plan to share additional information in each issue of *Seasons*[™] Magazine.

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Seasons

Myths about menopause

Finally, the mystique about menopause has been lifted. Robin Marantz Henig separates the myths from the latest facts about this long-misunderstood time in life.



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Very "AH" spa drinks

When it comes to replenishing your body's needs for liquids, drinking water can become tiresome. Try some healthy and tasty concoctions from the kitchens of famous spas.

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A spa for every reason

Whether you want to work off extra pounds, quit smoking, pamper your body, or just plain relax, there's a spa for you. Here's a checklist for finding the spa that matches your dreams.

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Rx for aging muscles: The home stretch

Does your body feel sluggish and weak? Maybe it's time to give your muscles a good stretch. Here's a 10-minute routine you can do at home that rejuvenates and relaxes your muscles.

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Rita Moreno helps combat the symptoms of menopause. Find out how.

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MYTHS

Menopause is almost always worse in the imagination than in

reality. Even in the enlightened 1990s, women worry that this “change of life,” bringing with it hot flashes, vaginal dryness and sleepless nights, represents the end of their sexuality. ♦ It’s time to clear the air of menopausal myths — to distinguish between symptoms that are normal and those that are extreme. ♦ By strict definition, menopause is the absence of bleeding for 12 consecutive months.

So, technically, a woman

ABOUT

doesn’t know until *after* she’s been through it. But most of us are aware of approaching menopause. During the climacteric — roughly the 10 years before and the 10 years after the last period — nearly all women experience some symptoms, most often hot flashes, mood swings, insomnia and lethargy. ♦ Here, then, are the most commonly-held beliefs about menopause — and its treatment.

MENOPAUSE

by Robin Marantz Henig

MYTH 1

Menopause Is a Disease.

This has long been presented as fact, but menopause isn't a disease at all. It's simply another stage of life — more clearly marked than others, but normal just the same.

True, a change occurs in the hormone profile: the ovaries gradually decrease their secretion of estrogen. But that does not mean an end to estrogen production. Even after the last menstrual period a woman's ovaries continue to manufacture the hormone — though in much smaller amounts. Indeed, estrogen is still produced by women in their eighties.

MYTH 2

Hot Flashes Are All in Your Mind.

In fact, they're in the body. According to Ann Voda, a nursing researcher at the University of Utah, at least 85 percent of women eventually have hot flashes. For several minutes the sufferer feels a distressing rush of heat to her chest, neck, face and arms; her skin reddens, her pulse quickens, her breathing becomes shallow and she breaks out in a sweat. Then, as fast as it came, it's over, often leaving the woman chilly and breathless. Some experience this sensation a few times a day; some as much as 5 to 10 times an hour; others, only at night.

"It's a kind of irritable heat, like playing two sets of tennis and then having to poke around in a weedy field looking for a lost ball," says Barbara Raskin, author of the novel *Hot Flashes*. "It's disconcerting, but not disabling."

What causes this disruption of the body's thermostat? Researchers believe that as the ovaries secrete less estrogen, the pituitary reacts by producing more of its hormones. This makes the body

think it is cooler than it is and activates the get-warm mode.

Hot flashes tend to be most severe in women who have had their ovaries removed. The symptoms usually disappear within a year or two, when the hormonal upheaval slows down, but some women continue to have them for as long as five years.

MYTH 3

Menopause Causes Depression and Anxiety.



Menopause does *not* cause psychiatric problems. In one study, Dr. Myrna M. Weissman, then at Yale University, found that the prevalence and severity of depression, for example, were no different during the menopausal years than it was for women under 45 or over 55.

But menopause can predispose a woman to irritability and moodiness. Mood swings are sometimes comparable to the highs and lows of another period of hormonal upheaval, puberty. It should be noted that taking estrogen will not relieve depression or anxiety. Estrogen may help with these problems only if they are caused by lack of sleep related to hot flashes or night sweats.

There's some truth to the notion that menopause saps a woman's strength. As she did during puberty and again during pregnancy, she may

crave sleep — and be unable to get it because of night sweats. Mild exercise and a bedtime cup of milk (it contains tryptophan, a natural sleep inducer) sometimes help.

MYTH 4

Menopause Causes Weight Gain.

The tendency to put on weight increases with age, but it has nothing to do with menopause. In fact, a typical woman gains most of her excess weight — an average of almost 10 pounds — between 35 and 45, and only another 2 pounds between 45 and 55.

Weight gain in mid-life has much the same cause as at any age: too much food intake for the amount of energy expended. The combination of overeating and underexercising is more likely with age — in part because daily caloric needs actually decline by 2 percent to 8 percent a decade.

MYTH 5

Menopause Destroys a Woman's Sex Drive.

Actually, interest in sex should be heightened after menopause. There's less estrogen to compete with testosterone — the male hormone that controls the libido and which women produce throughout life.

One thing can interfere with a woman's continuing sexual desire: vaginal dryness. Physical discomfort can occur during intercourse caused by a thinning out and drying of the vaginal walls. Women who achieve orgasm three or more times a month, however, are less likely to suffer from vaginal atrophy.

If a sexually active woman does remain painfully dry, doctors often recommend a water-soluble lubricant be used, such as K-Y Jelly.

MYTH 6

Women Who Take ERT Are at High Risk of Cancer

In the 1970s estrogen use was found to be associated with an increased risk of cancer of the uterus. But changes in the way estrogen-replacement therapy (ERT) is now administered have led gynecologists to consider it relatively safe for many women in the 1990s.

When estrogen is given alone, there is a risk of endometrial hyperplasia (an overgrowth of the endometrium, which is the lining of the uterus). In some instances, this may lead to cancer of the endometrium. Some doctors may recommend that ERT be combined with another hormone called progestin that causes the uterus to shed built-up tissue at the end of each cycle. This "cycled therapy" simulates the normal patterns of the menstrual cycle and prevents overgrowth of the endometrium. One of the consequences of cycled therapy is the return of light menstrual periods, though they are not associated with PMS or cramps. This does not mean a woman can become pregnant. What this means is that cycled therapy is helping to protect the endometrium. Some progestins may possibly cause unfavorable changes in levels of fats and sugar in the blood. But these changes can be kept to a minimum by changing to another progestin and/or changing the dosage.

The relationship between ERT and breast cancer has been studied for years. Most studies indicate that estrogen, especially at low doses, does not increase the risk of breast cancer. Studies that have shown a connection have usually involved women who took estrogen at higher doses for prolonged periods of time.

Regular breast examinations by a health professional and self-examination are recommended for women

receiving estrogen therapy, as they are for all women.

Adapted from *Woman's Day Magazine*.
Used with permission.

Charting The Changes

Here are some of the major changes that can occur with menopause. The symptoms – and their sheer number – can be intimidating, but most women experience only a few of them, often in a mild form.

When	Symptom	Comments
Before Menopause	irregular periods	Cycle may shorten or lengthen; flow may increase or decrease. Women may continue to be fertile until they have been without periods for one year.
During Menopause	periods stop	—
	hot flashes	Skin temperature rises, then falls. Accompanied by sweating and sometimes heart palpitations, nausea and anxiety. Frequency ranges from once a month to several an hour; most last about five minutes. Hot flashes may begin 12 to 18 months before menopause, and continue for some years after periods end.
	insomnia	Sometimes caused by nightly bouts of hot flashes. Dream-rich REM sleep may also decrease, disturbing sleep.
	psychological effects	Irritability, short-term memory loss, and problems with concentration are common. These symptoms may simply result from sleep deprivation. Some women experience decreased sexual desire.
After Menopause	vaginal dryness	The mucosal membranes and walls of the vagina become thinner, which may lead to pain upon intercourse and susceptibility to infections.
	bone loss	Increases dramatically.
	dry skin and hair	The skin can become thin, dry, and itchy. Hair may also thin out. Facial hair may increase.
	incontinence	Tissue shrinkage in the bladder and weakening pelvic muscles may lead to problems with bladder control. Susceptibility to urinary tract infections may increase.
	cardiovascular changes	Blood vessels become less flexible. Cholesterol and triglyceride levels rise.
	changes in nervous system	The perception of touch can become more or less sensitive.

By Lisa Davis. Reprinted from *In Health* magazine. Copyright © 1989.

Very "AH"

Spa Drinks by Lucy Saunders



Have you ever tried to stick to a 1,200 calorie-per-day diet? Then the harsh realities of portion control come as no surprise to you. When confronted with a minuscule amount of manicotti, you may feel hungry even after eating. Take this tip from the nutritionists and chefs at spas nationwide: Drink plenty of fluids.

Susan Witz, a registered dietitian who works for The Heartland, a health and fitness spa in Gilman, IL, says, "Most people are under-hydrated most of the time, without even realizing it."

Part of this is due to Americans' preference for soft drinks, which often contain caffeine. "Caffeine depletes the body of fluids," says Witz, "so

caffeinated beverages should not be counted in the day's liquid intake."

Today, we know that water is a key component of the energy reactions in the body. Water helps transport nutrients in the system, and without sufficient water, the body functions poorly. A secondary benefit to drinking plenty of water is that it eases the digestive tract's transition to a high-fiber diet. Witz says, "You can't overdo it when drinking water. It's difficult to take in too much."

Most readers would disagree with Witz. I know that I tire of the tastelessness of water long before I reach the 10-glass-per-day mark. For this reason, more flavorful alternatives

often are served at spas. Michael Stroot, former master chef at Cal-à-Vie Spa in Vista, CA, is an expert on the light food and cooking style known in Europe as "cuisine fraîche." "Good drinks go a long way to refreshing you after a tough workout," Stroot notes. "I see so many guests of the spa look as if they were drooping plants in need of water." Rather than serve water after an aerobic workout, Stroot serves his Revitalizer drink. His toast to me was, "Drink it in good health!"

The Cal-à-Vie Revitalizer

Yield: 12 8-oz servings

Ingredients:

- 1 48-oz can low-sodium vegetable cocktail juice
- 48 oz water
- 2 stalks celery, chopped coarsely
- 1 large carrot, chopped coarsely
- 1 bunch parsley, washed but not trimmed
- 2 bay leaves
- 1/2 tsp crushed chili flakes (to taste)
- 2 tsp dried rosemary
- 1/2 tsp fennel seed
- 4 sprigs fresh basil, or 1 Tbs dried basil
- 2 C cut vegetables (mushrooms, turnips, parsnips, tomatoes, onion, red or green peppers, snow peas, etc.)

Method:

Put all ingredients into a large stock pot. Simmer over low heat for 40-60 minutes. Strain broth into a pitcher. (Leftover vegetables may be discarded or pureed and added to soups.) Serve hot or cold.

Per 8-oz serving:

Calories: 30
Protein: 1.3 g
Fat: 0.1 g
Carbohydrates: 6.5 g

A Spa For Every Reason

A checklist for finding a spa that's right for you

by Marcia Powell

Spas are no longer limited to the "fat farm" grind; today's health spas are designed to revitalize both body and mind. In addition to shedding a few pounds, you can develop health-conscious habits, be pampered, meet interesting new people or find solitude. Many spa programs are multifaceted and specialized, offering everything from executive fitness to lifestyle reorientation programs.

If a spa getaway appeals to you, these are the initial considerations:

Decide what's most important to

you – pampering, weight loss, shaping up, kicking a health-threatening habit (tobacco, alcohol or drug abuse), learning ways to combat stress or a combination of elements. Also, decide if total freedom or a more regimented program has more appeal to you. Then:

- Shop around. Spas run the gamut from super luxury to spartan. Facilities, staff, accommodations, services and philosophies vary. Collect brochures and other information about a number of spas, then compare what you'll get

at each. (Addresses and phone numbers for some of the best spas are listed.)

- Ask a travel agent for recommendations. Talk with friends or associates about spas they've visited. What did they like and dislike?

Now, from the literature or a discussion with a spa representative, make more specific determinations:

- Are your arrival and departure dates standardized or can you come and go when it's convenient for you? Is a minimum stay required?

- Is the price all-inclusive or will you be charged extra for some programs or services? Are staff



gratuities and taxes part of the quoted price? If not, how much will these add to your bill?

- Does the spa provide transportation to and from the airport, train or bus station? If you're driving, what parking facilities are available?

- What's the staff-guest ratio? What are the credentials of the staff members and do they include full-time medical personnel?

- What special programs are available (executive fitness, life-style changes, nutritional counseling, stress management)?

- Are single accommodations available? Can someone not on the spa

program accompany you? Is the spa co-ed or "for women only"?

- If you'll be traveling with others, are there activities to keep them amused if they're not interested in the spa program? Are there non-spa activities (golf, tennis, sightseeing, etc.) that you'd like, too?

- Does the spa provide movies, lectures, dancing, a game room or other evening entertainment?

- What clothing will you need? Some spas are totally casual while others mix casual daytime attire with dressier dinner wear.

Now decide for yourself:

- Do the climate and location (desert, mountains, city, etc.) of the spa appeal to you?

- Do the exercise and diet programs appeal to you?

A Spa Sampler

The Ashram, P.O. Box 8009, Calabasas, CA 91302; 818/222-6900.

The Aspen Club, 1450 Crystal Lake Rd., Aspen, CO 81611; 303/925-8900.

The Bonaventure, 250 Racquet Club Rd., Ft. Lauderdale, FL 33326; 800/327-8090.

Cal-à-Vie, 2249 Somerset Rd., Vista, CA 92084; 619/945-2055.

Canyon Ranch in Tucson, AZ and Lenox, MA; for information on both: 8600 E. Rockcliff Rd., Tucson, AZ 85715; 800/742-9000; 602/749-9000.

Doral Saturnia International Spa Resort, 8755 N.W. 36th St., Miami, FL 33178-2401; 800/331-7768; in Florida, 800/247-8901.

French Lick Springs Golf & Tennis Resort Spa, French Lick, IN 47432; 800/457-4042; 812/936-9300.

The Golden Door, P.O. Box 1567, Escondido, CA 92033; 619/744-5777.

The Greenhouse, P.O. Box 1144, Arlington, TX 76004; 817/640-4000.

The Heartland (Gilman, IL), 20 E. Jackson, Suite 300, Chicago, IL 60604; 312/427-6465; 800/545-4853.

The Kerr House, 17777 Beaver St., Grand Rapids, OH 43522; 419/832-1733.

La Costa, 2100 Costa del Mar Rd., Carlsbad, CA 92009; 619/438-9111; 800/854-5000.

The Inn of the Six Mountains, P.O. Box 225, Killington, VT 05751; 802/422-4302.

The Norwich Inn Spa and Villa, 607 W. Thames Street, Norwich, CT 06360; 800/892-5692.

The Oaks, 122 E. Ojai Ave., Ojai, CA 93023; 805/646-5573; 800/753-6257.

Olympia Resort & Spa, 1350 Royal Mile Road, Oconomowoc, WI 53066; 800/558-9573.

Palm-Aire Spa, Resort, and Country Club, 2501 Palm-Aire Dr. N., Pompano Beach, FL 33069; 800/272-5624.

Pheasant Run Resort & Tower Club Spa, 4051 E. Main St., St. Charles, IL 60174-5200; 708/584-6300.

The Phoenix Spa, 119 N. Post Oak Lane, Houston, TX 77024; 713/680-1601.

Rancho La Puerta (Mexico), P.O. Box 2548, Escondido, CA 92033; 800/443-7565; 619/744-4222.

Safety Harbor Spa & Fitness Center, 105 N. Bayshore Dr., Safety Harbor, FL 34695; 800/237-0155; in Florida, 813/726-1161 (collect).

Sonoma Mission Inn Spa, P.O. Box 1447, Sonoma, CA 95476; 800/358-9022; in California, 707/938-9000.

Vista Clara Health Retreat & Spa, Box 111, Galisteo, NM 87540; 800/247-0301.



Rx for aging muscles:

THE HOME STRETCH

*A 10-minute routine that relaxes and
rejuvenates muscles*



It's a fact of life: Our bodies tend to lose flexibility over time from the effects of gravity and inactivity. The process is gradual and, fortunately, reversible. A simple stretching program, taking as little as 10 minutes a day, can help to relax, rejuvenate, and rebalance your muscles.

to 60 seconds, then straighten up slowly. Repeat with legs reversed.

Neck stretch. Sitting in a chair, shrug your shoulders and then relax them (don't just let go – relax the shoulders with control). Repeat this motion until your neck and shoulders are free from tension. Next, slowly turn

TCF

Daniel Kosich, an exercise consultant in Albuquerque, identifies five areas that are most likely to tighten with age: The calf muscles, the hamstrings, the large hip flexors that bend the thighs forward at the hips, the muscles of the lower back, and the chest muscles. The neck can also become tight, Kosich says, from the strain of lifting the head to counteract poor posture created by tightness elsewhere.

To improve flexibility, it's important to stretch all five trouble spots. The following exercises offer basic routines to help you get started. Note: If you have health conditions that affect your flexibility, you might want to speak with your doctor before starting any exercise program.

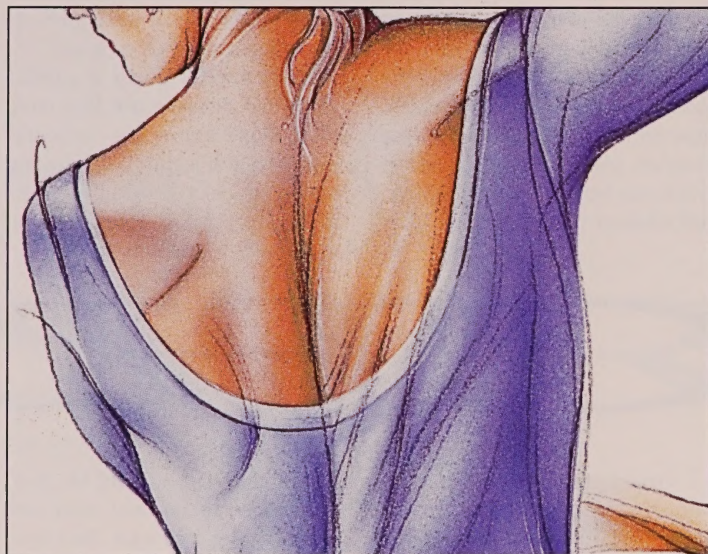
Calf-achilles stretch. This stretch can be done with hands on hips, or holding onto a chair or wall for support.

Stand comfortably, with your feet a few inches apart. Move your right foot back until your right toes are even with your left heel. Keeping both feet flat on the floor, bend both knees, with your weight over your right foot, so your center of gravity drops straight down through your right foot. Go down slowly until you feel a stretch in your right achilles tendon. Hold for 20

your head all the way to the left, then return it to the normal front and center position, and relax. Then turn your head all the way to the right, return it to the center, and relax again. For a good supplemental stretch, slowly roll your head in a full circle while keeping your back vertical and your shoulders relaxed. Rotate your head 8 to 10 times in each direction.

Chest stretch. While standing or sitting, lace your fingers behind your back, with your palms facing in toward your spine. Raise your hands toward the ceiling until you feel a stretch in the front of your chest. Don't arch your back, and be sure to keep your neck in a neutral, relaxed position. Hold this position for 20 to 60 seconds. As an alternative stretch: Start the same way, but instead of raising your arms, try pulling your shoulder blades toward each other.

Hamstring stretch. Lie on your back and bend your left leg, keeping your left foot flat on the floor. Keeping your right leg straight (but not locking your knee), lift it from the hip until you feel a gentle stretch in your right hamstring. Hold that position for 20 to 60 seconds. Then repeat with legs reversed. You can clasp your hands behind your knees or use a towel to help pull back your leg.



Rita Moreno's Menopause Relief

by Marcia Powell

Rita Moreno, who is 58, discovered that a regular exercise program relieved the effects of an emotionally difficult menopause: "My menopause was very rough – a lot of weeping, a lot of anger – and I didn't know what was happening. One day when I was feeling so despairing, I went to an aerobics class. Within 10 minutes I was feeling better; in 20 minutes even better; and by the end of the class I was almost skipping out the door. Exercise can cure the blues, anger, and frustration faster than anything else I know."



STRETCHING POINTERS

- **Don't hold your breath:** This triggers an automatic response that raises your blood pressure and tightens your muscles. Instead, breathe slowly and steadily as you stretch.

- **If you exercise at home,** you may want to get a comfortable mat to stretch on.

- **Stretch only to the point** where you feel a pleasant tension in the specific muscle you're stretching – and never to the point of discomfort.

- **As you stretch,** concentrate on keeping your neck relaxed and avoid arching your back.

- **Stretch within 5 to 10 minutes** after finishing an aerobic workout.

- **If you are stretching after a warm-up,** hold each stretch for 20 to 60 seconds.

- **If you are stretching "cold,"** hold the stretch for 10 to 20 seconds.

Hip flexor stretch. With your left knee resting on the floor, move your right leg forward so your right knee is directly above your right ankle and your right foot is flat on the ground. Place both hands on the floor for support. Then, without changing the position of your left knee or right foot, lower your left hip. A slight downward movement will produce a stretching sensation in the front of your hip. Hold, then repeat with legs reversed.

Breathing stretch. Holding a light weight in both hands, lie on your back on a table or bed so your head and arms extend off the end. With elbows bent and upper arms parallel, slowly lower the weight back over your head, inhale deeply to feel a stretch in your ribs and stomach, then exhale completely. Repeat.

Lower back stretch. Lie on your back with your legs extended. Bend your right leg, holding the back of your knee with both hands, and pull it toward your chest, keeping your left leg very straight. Repeat with the left leg, then with both legs together. Alternatively, do this exercise with both knees bent.

First published in *NEW CHOICES* Magazine, January 1991

PREMARIN® (conjugated estrogens tablets, USP)

CAUTION: Federal law prohibits dispensing without prescription.

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA IN POSTMENOPAUSAL WOMEN

Close clinical surveillance of all women taking estrogens is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to rule out malignancy in all cases of undiagnosed persistent or recurring abnormal vaginal bleeding. There is currently no evidence that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equieffective doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

Estrogen therapy is associated with an increased risk of congenital defects in the reproductive organs of the male and female fetus, an increased risk of vaginal adenocarcinoma, squamous cell dysplasia of the uterine cervix, and vaginal cancer in the female later in life. The 1985 DES Task Force concluded that women who used DES during their pregnancies may subsequently experience an increased risk of breast cancer. However, causal relationship is still unproven, and the observed level of risk is similar to that for a number of other breast cancer risk factors.

There is no indication for estrogen therapy during pregnancy. Estrogens are ineffective for the prevention or treatment of threatened or habitual abortion.

DESCRIPTION: PREMARIN (conjugated estrogens tablets, USP) for oral administration contains a mixture of estrogens obtained exclusively from natural sources, occurring as the sodium salts of water-soluble estrogens. It is formulated to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilenin, and 17 β -dihydroequilin as salts of their sulfate esters. Tablets for oral administration are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens.

PREMARIN tablets contain the following inactive ingredients: calcium phosphate tribasic, calcium sulfate, carnauba wax, cellulose, glyceryl monoleate, lactose, magnesium stearate, methylcellulose, pharmaceutical grade, polyethylene glycol, stearic acid, sucrose, talc, titanium dioxide. Each 0.3 mg tablet also contains: Yellow No. 1, FD&C Yellow No. 6; Each 0.625 mg tablets also contain: FD&C Blue No. 2, D&C Red No. 27, FD&C Red No. 40; Each 0.9 mg tablets also contain: D&C Red No. 6, D&C Red No. 7, polyisobutyl 20; Each 1.25 mg tablets also contain: black iron oxide, D&C Yellow No. 10, FD&C Yellow No. 6; Each 2.5 mg tablets also contain: FD&C Blue No. 2, D&C Red No. 7.

CLINICAL PHARMACOLOGY: Estrogens are important in the development and maintenance of the female reproductive system and secondary sex characteristics. They promote growth and development of the vagina, uterus, and fallopian tubes, and enlargement of the breasts. Indirectly, they contribute to the development of the skeleton, the maintenance of the elasticity of urogenital structures, changes in the epiphyseal of the long bones that allow for the pubertal growth spurt and its termination, growth of axillary and pubic hair, and pigmentation of the nipples and genitals. Decline of estrogen of the menstrual cycle and the cessation of the growth spurt, although the cessation of progesterone secretion is the most important factor in the mature ovulatory cycle. However, in the preovulatory or nonovulatory cycle, estrogen is the primary determinant in the onset of menstruation. Estrogens also affect the release of pituitary gonadotropins.

The pharmacologic effects of conjugated estrogens are similar to those of endogenous estrogens. They are soluble in water and are well absorbed from the gastrointestinal tract. In responsive tissues (female genital organs, breasts, hypothalamus, pituitary) estrogens enter the cell and are transported into the nucleus. As a result of estrogen action, specific RNA and protein synthesis occurs.

Metabolism and inactivation occur primarily in the liver. Some estrogens are excreted into the bile; however, they are reabsorbed from the intestine and returned to the liver through the portal venous system. Water-soluble and non-soluble estrogens and their metabolites are excreted in body fluids, which factor excretion through the kidneys since tubular reabsorption is minimal.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP) is indicated in the treatment of:

1. Moderate to severe vasomotor symptoms associated with the menopause. There is no adequate evidence that estrogens are effective for nervous symptoms or depression which might occur during menopause and they should not be used to treat these conditions.
2. Atrophic vaginitis.
3. Atrophic urethritis.
4. Osteoporosis (loss of bone mass). The mainstays of prevention and management of osteoporosis are estrogen and calcium; exercise and nutrition may be important adjuncts.
5. Estrogen replacement therapy is the most effective single modality for the prevention of osteoporosis in women. Estrogen reduces the rate of bone resorption and refills postmenopausal bone loss. Case-controlled studies have shown an approximately 60 percent reduction in hip and wrist fractures in women whose estrogen replacement was begun within a few years of menopause. Studies also suggest that estrogen reduces the rate of vertebral fractures. Even when started as late as 6 years after menopause, estrogen prevents further loss of bone mass but does not restore it to premenopausal levels. The lowest effective dose for prevention and treatment of osteoporosis should be utilized. (See **DOSAGE AND ADMINISTRATION**.)

Women are at higher risk than men because they have less bone mass and, for several years following natural or induced menopause, the rate of bone mass decline is accelerated. Early menopause is one of the strongest predictors for the development of osteoporosis. White women are at higher risk than black men and at higher risk than white men. In both groups, underweight is one of the strongest predictors for the development of osteoporosis. Cigarette smoking may be an additional factor in increasing risk. Calcium deficiency has been implicated in the pathogenesis of this disease. Therefore, when not contraindicated, it is recommended that postmenopausal women receive an elemental calcium intake of 1000 to 1500 mg daily. Immobilization and prolonged bed rest produce rapid bone loss, while weight-bearing exercise has been shown both to reduce bone loss and to increase bone mass. The optimal type and amount of physical activity that can prevent osteoporosis have not been established.

5. Hypoestrogenism due to hypogonadism, castration, or primary ovarian failure.

6. Breast cancer (for palliation only) in appropriately selected women and men with metastatic disease.

Advanced androgen-dependent carcinoma of the prostate (for palliation only).

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions:

1. Known or suspected pregnancy (See Boxed Warning). Estrogen may cause fetal harm when administered to a pregnant woman.
2. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease.
3. Known or suspected estrogen-dependent neoplasia.
4. Undiagnosed abnormal genital bleeding.
5. Active thrombophlebitis or thromboembolic disorders.
6. Women on estrogen replacement therapy have not been reported to have an increased risk of thrombophlebitis and/or thromboembolic disease. However, there is insufficient information regarding women who have had previous thromboembolic disease.

PREMARIN tablets should not be used in patients hypersensitive to their ingredients.

WARNINGS: 1. **Induction of malignant neoplasms.** Some studies have suggested a possible increased incidence of breast cancer in those women on estrogen therapy taking higher doses for prolonged periods and/or in a majority of studies, however, have not shown an association with the usual doses used for estrogen replacement therapy. Women on this therapy should have regular breast examinations and should be instructed in breast self-examination. The reported endometrial cancer risk among women who used was about 4-fold or greater than in nonusers and appears dependent on duration of treatment and on estrogen dose. There is no significant increased risk associated with the use of estrogens for less than one year. The greatest risk appears associated with prolonged use—five years or more. In one study, persistence of risk was demonstrated for 10 years after cessation of estrogen therapy. In another study, a significant decrease in the incidence of endometrial cancer occurred six months after estrogen withdrawal.

Estrogen therapy during pregnancy is associated with an increased risk of fetal congenital reproductive tract disorders. There is an increased risk of vaginal adenocarcinoma, squamous cell dysplasia of the cervix, and cancer later in life, in the male, urogenital abnormalities. Although some of these changes are benign, it is not known whether they are precursors of malignancy.

2. **Gallbladder disease.** A recent study has reported a 2.5-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.
3. **Cardiovascular disease.** Large doses of estrogen (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown in a large prospective clinical trial to increase the risk of non-fatal myocardial infarction, pulmonary embolism, and thrombophlebitis. It cannot necessarily be extrapolated from men to women. However, to avoid the theoretical cardiovascular risk caused by high estrogen doses, the doses for estrogen replacement therapy should not exceed the recommended dose.
4. **Elevated blood pressure.** There is no evidence that this may occur with use of estrogens in the menopause. However, blood pressure should be monitored with estrogen use, especially if high doses are used.

5. **Hypocalcemia.** Administration of estrogens may lead to severe hypocalcemia in patients with breast cancer and bone metastases. If this occurs, the drug should be stopped and appropriate measures taken to reduce the serum calcium level.

PRECAUTIONS:

A. General

1. **Addition of a progestin.**—Studies of the addition of a progestin for seven or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether the addition of a progestin provides protection from endometrial cancer is not clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. The potential risks include adverse effects on carbohydrate and lipid metabolism. The choice of progestin and dosage may be important in minimizing these adverse effects.

2. **Physical examination.**—A complete medical and family history should be taken prior to the initiation of any estrogen therapy. The pretreatment and periodic physical examinations should include special reference to provide protection from endometrial, cervix, and ovarian cancer, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed.

3. **Fluid retention.**—Estrogens may cause fluid retention, which may be associated with fluid retention, conditions which might be influenced by this factor, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation.

4. **Uterine bleeding and mastodynia.**—Certain patients may develop undesirable manifestations of estrogen stimulation, such as abnormal uterine bleeding and mastodynia.

5. **Uterine fibroids.**—Preexisting uterine leiomyomata may increase in size during prolonged high-dose estrogen use.

6. **Impaired liver function.**—Estrogens may be poorly metabolized in patients with impaired liver function and should be administered with caution.

7. **Hypocalcemia and renal insufficiency.**—Prolonged use of estrogens can alter the metabolism of calcium and phosphorus. Estrogens should be used with caution in patients with metabolic bone disease.

8. **Information for the Patient.**—See text of Patient Package Insert which appears after the HOW SUPPLIED section.

9. **Laboratory Tests.**—Clinical response at the smallest dose should generally be the guide to estrogen administration for relief of symptoms for those indications in which symptoms are observable. However, for prevention and treatment of osteoporosis see **DOSAGE AND ADMINISTRATION** section. Tests used to measure adequacy of estrogen replacement therapy include serum estrone and estradiol levels and supine and standing serum gonadotropin.

10. **Drug/Laboratory Test Interactions.**—Some of these drug/laboratory test interactions have been observed only with estrogen-progestin combinations (oral contraceptives):
 - a. Reduced response to thyroid function tests.
 - b. Reduced response to prothrombin time and partial thromboplastin time.
 - c. Increased norepinephrine-induced platelet aggregability, decreased fibrinolysis.

11. **Increased thyroid-binding globulin (TBG) level** to increased circulating total thyroid hormone, as measured by T4 levels determined either by column or by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

12. **Impaired glucose tolerance.**
13. **Reduced response to metoprolol test.**
14. **Reduced serum folate concentration.**

15. **Mutagenesis and Carcinogenesis.**—Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver.

16. **Pregnancy Category X.**—Estrogens should not be used during pregnancy. See **CONTRAINDICATIONS** and **Boxed Warning**.

17. **Nursing Mothers.**—As a general principle, the administration of any drug to nursing mothers should be deferred until the child is weaned, because of the potential for adverse effects on the child.

ADVERSE REACTIONS: (See **WARNINGS**.) The following adverse effects on the fetus, increased incidence of gallbladder disease.) The following additional adverse reactions have been reported with estrogen therapy:

1. **Gonorrhea.**—Symptoms: Changes in vaginal bleeding pattern and abnormal whitening/burning of the vulva, increased vaginal discharge, spotting, increase in size of uterine fibromyoma, vaginal candidiasis. Change in amount of cervical secretion.

2. **Breasts:** Tenderness, enlargement.
3. **Gastrointestinal:** Nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice.

4. **Skin:** Chloasma or melasma that may persist when use is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism.
5. **Eyes:** Steeping of corneal curvature; intolerance of contact lenses.

6. **CNS:** Headache, dizziness, depression, nervousness, nervousness, nervousness, nervousness.
7. **Miscellaneous:** Increase or decrease in weight, reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: Numerous reports of ingestion of large doses of estrogen-containing oral contraceptives by young children indicate that acute serious ill effects do not occur. Overdose of estrogen may cause nausea, vomiting, and bleeding.

DOSAGE AND ADMINISTRATION:

1. For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, and atrophic urethritis associated with the menopause. The lowest dose that will control symptoms should be chosen and medication should be discontinued when symptoms are controlled.

Attempts to discontinue or taper medication should be made at 3-month to 6-month intervals.

Usual dosage ranges:

Vasomotor symptoms—1.25 mg daily. If the patient has not menstruated within the last two months (more than 6 months), cyclic administration is started on the first day of menstruation, cyclic (eg, three weeks on and one week off) administration is started on day 5 of bleeding.

Atrophic vaginitis and atrophic urethritis—0.3 mg to 1.25 mg or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

2. Hypoestrogenism due to:

- a. Female hypogonadism—2.5 mg to 7.5 mg daily, in divided doses for 20 days, followed by a rest period of 10 days' duration. If bleeding does not occur by the end of this period, the same dosage schedule is repeated. The frequency of courses of estrogen therapy necessary to produce bleeding may vary depending on the responsiveness of the endometrium.

If bleeding occurs during the end of the 10-day period, begin a 20-day estrogen-progestin cycle regimen with PREMARIN (conjugated estrogens tablets, USP) 0.3 mg to 7.5 mg daily, in divided doses, for 20 days. During the last five days of estrogen therapy, give an oral progestin. If bleeding occurs before this regimen is concluded, therapy is discontinued and may be resumed on the fifth day of bleeding.

- b. Female castration or primary ovarian failure—1.25 to 2.5 mg daily, cyclically. Adjust dosage, upward or downward, according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

3. Osteoporosis (loss of bone mass)—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

4. Advanced androgen-dependent carcinoma of the prostate, for palliation only—1.25 mg to 2.5 mg three times daily. The effectiveness of therapy can be judged by phosphate determinations as well as by symptoms and physical improvement of the patient.

5. Breast cancer (for palliation only) in appropriately selected women and men with metastatic disease. Suggested dosage is 10 mg three times daily for a period of at least three months.

Each oral white tablet contains 0.3 mg, in bottles of 100 (NDC 0046-0865-81) and 1,000 (NDC 0046-0867-91); 0.625 mg, in bottles of 100 (NDC 0046-0866-81) and 1,000 (NDC 0046-0868-91); 0.9 mg, in bottles of 100 (NDC 0046-0867-81) and 1,000 (NDC 0046-0868-81); 1.25 mg, in bottles of 100 (NDC 0046-0867-91) and 1,000 (NDC 0046-0868-91); 2.5 mg, in bottles of 100 (NDC 0046-0865-81) and 1,000 (NDC 0046-0867-91).

Each oral yellow tablet contains 2.5 mg, in bottles of 100 (NDC 0046-0865-81) and 1,000 (NDC 0046-0867-91).

Each oral white tablet contains 0.3 mg, in bottles of 100 (NDC 0046-0865-81) and 1,000 (NDC 0046-0867-91); 0.625 mg, in bottles of 100 (NDC 0046-0866-81) and 1,000 (NDC 0046-0868-91); 0.9 mg, in bottles of 100 (NDC 0046-0867-81) and 1,000 (NDC 0046-0868-81); 1.25 mg, in bottles of 100 (NDC 0046-0867-91) and 1,000 (NDC 0046-0868-91); 2.5 mg, in bottles of 100 (NDC 0046-0865-81) and 1,000 (NDC 0046-0867-91).

The appearance of these tablets is a trademark of Ayerst Laboratories. Store at room temperature (approximately 25°C).

INFORMATION FOR THE PATIENT

This leaflet describes when and how to use estrogens and the risks of estrogen treatment.

ESTROGEN DRUGS: Estrogens have several important uses but also some risks. You must decide, with your doctor, whether the risks of estrogens are acceptable and whether you decide to start or stop estrogen therapy. Check with your doctor to make sure you are using the lowest possible effective dose. The length of treatment with estrogens will depend upon the reason for use. This should also be discussed with your doctor.

USES OF ESTROGEN:

To reduce menopausal symptoms—Estrogens are hormones produced by the ovaries. The decrease in the amount of estrogen that occurs in all women, usually between ages 45 and 55, causes the menopause. Sometimes the ovaries are removed by an operation, causing "surgical menopause." When the amount of estrogen begins to decrease, some women develop very uncomfortable symptoms, such as feelings of warmth in the face, neck, and chest or sudden intense episodes of heat and sweating ("hot flashes"). The use of drugs containing estrogens can help the body adjust to lower estrogen levels.

Most women have none or only mild menopausal symptoms and do not need estrogens. Other women may need estrogens for a few months while their bodies adjust to lower estrogen levels. The majority of women do not need estrogen replacement for longer than six months for these symptoms.

To prevent brittle bones—After age 40, and especially after menopause, some women develop osteoporosis. This is a thinning of the bones that makes them weaker and more likely to break, often leading to fractures of vertebrae, hip, and wrist bones. Taking estrogens after the menopause slows down bone loss and may prevent bones from breaking. Eating foods that are high in calcium (such as milk products) or taking calcium supplements (1000 to 1500 milligrams per day) and certain types of exercise may also help prevent osteoporosis.

Since estrogen use is associated with some risk, its use in the prevention of osteoporosis should be confined to women who appear to be susceptible to this condition. The following characteristics are often present in women who are likely to develop osteoporosis: white race, thinness, and cigarette smoking.

Women who had their menopause by the surgical removal of their ovaries at a relatively young age are good candidates for estrogen replacement therapy to prevent osteoporosis.

To treat certain types of abnormal uterine bleeding due to hormonal imbalance.

To treat atrophic vaginitis (itching, burning, dryness in or around the vagina) and **atrophic urethritis** (which may cause difficulty or burning on urination).

To treat certain cancers.

WHEN ESTROGENS SHOULD NOT BE USED:

Estrogens should not be used:

During pregnancy—Although the possibility is fairly small, there is a greater risk of having a child born with a birth defect if you take estrogens during pregnancy. A male child may have an increased risk of developing abnormalities of the urinary system and sex organs. A female child may have an increased risk of developing cancer of the vagina or cervix in her teens or twenties. Estrogen is not effective in preventing miscarriage (abortion).

If you have had any heart or circulation problems—Estrogen therapy should be used only after consultation with your physician, and only in recommended doses. Patients with a tendency for abnormal blood clotting should avoid estrogen use (see below).

If you have had cancer—Since estrogens increase the risk of certain cancers, you should not take estrogens if you have ever had cancer of the breast or uterus. In certain situations, your doctor may choose to use estrogen in the treatment of breast cancer.

When they are ineffective—Sometimes women experience nervous symptoms or depression during menopause. There is no evidence that estrogens are effective for such symptoms. You may have heard that taking estrogens for long periods (years) after menopause will keep your skin soft and supple and keep you feeling young. There is no evidence that this is so and such long-term treatment may carry serious risks.

DANGERS OF ESTROGENS:

Cancer of the uterus—The risk of cancer of the uterus increases the longer estrogens are used and when larger doses are taken. One study showed that when estrogens are discontinued, this increased risk of cancer seems to fall off quickly. In another study, the persistence of risk was demonstrated for 10 years after stopping estrogen treatment. Because of this risk, it is important to take the lowest dose of estrogen that will control your symptoms and to take it only as long as you need it. There is a higher risk of cancer of the uterus if you are overweight, diabetic, or have high blood pressure.

If you have had your uterus removed (total hysterectomy), there is no danger of developing cancer of the uterus.

Cancer of the breast—The majority of studies have shown no association with the usual doses used for estrogen replacement therapy and breast cancer. Some studies have suggested a possible increased

incidence of breast cancer in those women taking estrogens for prolonged periods of time and especially if higher doses are used.

Regular breast examinations by a health professional and self-examination are recommended for women receiving estrogen therapy, as they are for all women.

Gallbladder disease—Women who use estrogens after menopause are more likely to develop gallbladder disease needing surgery than women who do not use estrogens.

Abnormal blood clotting—Taking estrogens may increase the risk of blood clots. These clots can cause a stroke, heart attack or pulmonary embolus, any of which may be fatal.

SIDE EFFECTS: In addition to the risks listed above, the following side effects have been reported with estrogen use:

- Nausea and vomiting
- Breast tenderness or enlargement
- Enlargement of benign tumors of the uterus
- Retention of excess fluid. This may make some conditions worsen, such as asthma, epilepsy, migraine, heart disease, or kidney disease.
- A spotty darkening of the skin, particularly on the face

REDUCING RISK OF ESTROGEN USE: If you decide to take estrogens, you can reduce your risks by carefully monitoring your treatment.

See your doctor regularly—While you are taking estrogens, it is important that you visit your doctor at least once a year for a physical examination. If members of your family have had breast cancer or if you have ever had breast nodules or an abnormal mammogram (breast x-ray), you may need to have more frequent breast examinations.

Reevaluate your need for estrogens—You and your doctor should reevaluate your need for estrogens at least every six months.

Be alert for signs of trouble—Report these or any other unusual side effects to your doctor immediately:

- Abnormal bleeding from the vagina
- Pains in the calves or chest, a sudden shortness of breath or coughing blood (indicating possible clots in the legs, heart, or lungs)
- Severe headache, dizziness, faintness or changes in vision, indicating possible clots in the brain or eye
- Breast lumps
- Yellowing of the skin
- Pain, swelling, or tenderness in the abdomen

OTHER INFORMATION: Some physicians may choose to prescribe another hormonal drug to be used in association with estrogen treatment. These drugs, progestins, have been reported to lower the frequency of occurrence of a possible precancerous condition of the uterine lining. Whether this will provide protection from uterine cancer has not been clearly established. There are possible additional risks that may be associated with the inclusion of a progestin in estrogen treatment. The possible risks include unfavorable effects on blood fats and sugars. The choice of progestin and its dosage may be important in minimizing these effects.

Your doctor has prescribed this drug for you and you alone. Do not give the drug to anyone else. If you will be taking calcium supplements as part of the treatment to help prevent osteoporosis, check with your doctor about the amounts recommended. Keep this and all drugs out of the reach of children. In case of overdose, call your doctor, hospital, or poison control center immediately.

This leaflet provides the most important information about estrogens. If you want to read more, ask your doctor or pharmacist to let you read the professional labeling.

HOW SUPPLIED: PREMARIN® (conjugated estrogens tablets, USP)—tablets for oral administration. Each oval purple tablet contains 2.5 mg. Each oval yellow tablet contains 1.25 mg. Each oval white tablet contains 0.9 mg. Each oval maroon tablet contains 0.625 mg. Each oval green tablet contains 0.3 mg.

The appearance of these tablets is a trademark of Ayerst Laboratories.

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Sound Advice

Put your hearing to the test – free. Just dial 800/222-EARS (or 3277) Monday through Friday between 9 am and 6 pm Eastern Standard Time. (If you live in Pennsylvania, dial 800/345-EARS). The toll-free number is part of a national project that has provided screenings for more than 5 million Americans. Operators will ask where

you live and give you a local phone number to call (there's usually no toll charge involved). Then follow the recorded instructions provided during the two-minute "test," which consists of four signals for each ear. If you don't hear all eight tones, you might need to have your hearing checked by an ear specialist. The operators will also provide referrals.

Walking Proof

Put on those walking shoes and hit the road: Here's even more evidence that serious strolling may improve your health. Larry A. Tucker, Ph.D., of Brigham Young University, studied the effects of walking on cholesterol levels of more than 3,600 adults and found that those who walked at least two and a half hours each week had high cholesterol less than half as often as nonwalkers.



"We already know that cardiovascular exercise such as walking strengthens the heart," Tucker says. "And now walking also is shown to benefit cholesterol levels." Those levels, which are linked to heart disease, were higher among older participants in the study.

NEW COLUMN COMING IN SEASONS

"I wish I could make my husband understand..."

When we spoke to women about the types of articles they'd like to see in *Seasons*, many said they needed help explaining the ups and downs of menopause to the men in their lives. We heard you,

and in upcoming issues of *Seasons*, we'll be responding with a regular column written for men about menopause. We're designing this column to be a tear-out section you can hand directly to your mate.

Mutant Veggies

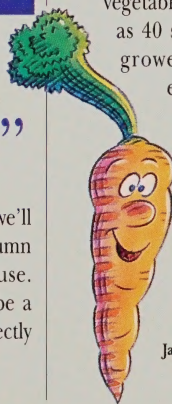
The President *hates* broccoli, but his reaction to broccoflower – a newly available hybrid cross between broccoli and cauliflower – is a closely guarded national secret. Public opinion, on the other hand, is positive.

This mutant form of cauliflower looks like a pale green version of its cousin and has a "very smooth texture with a somewhat sweeter taste than regular cauliflower, and without the smell of broccoli," according to George Gowgani, Ph.D., of California Polytechnic State University's crop science department.

Another Cal Poly scientist, Joseph Montecalvo, Ph.D., has analyzed the vegetable for its nutritional content. The result? Broccoflower is very high in vitamin C and folic acid. "In fact," says Montecalvo, "its vitamin C content is higher than that of oranges." (Folic acid strengthens the body's immune system.)

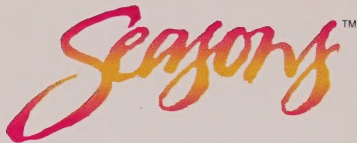
Dr. Montecalvo's students shipped some of the broccoflower to the White House, but there's been no official reaction from the President. If you want to try it in your house, the vegetable is available in as many as 40 states, according to the growers. It's a little more expensive than either broccoli or cauliflower.

Use it as a substitute in any of your favorite recipes for these members of the cabbage family.



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Here's the issue of *Seasons* Magazine you requested.



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in Female Healthcare™*



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